MDR Tracking Number: M5-04-2117-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on March 12, 2004.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the majority of the issues of medical necessity. The patient re-evaluation, electrical stimulation, massage therapy, ultrasound, office visits, aquatic therapy, therapeutic exercises, psychiatric diagnostic exam from 11-04-03 through 12-17-03 **were found** to be medically necessary. The patient re-evaluation, electrical stimulation, massage therapy, ultrasound, office visits, aquatic therapy, therapeutic exercises, psychiatric diagnostic exam from 12-22-03 through 01-08-04 were not found to be medically necessary. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this Order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 06-17-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Max. Allowable Reimbursement)	Reference	Rationale
11-05-03	99080-73	$15.00	$0.00	F	$15.00	Medicare Fee Guidlines Rule 134.202(C)	Requestor submitted relevant information to support service rendered, therefore the disputed service will be reviewed according to the Medicare Fee Guidelines. Recommend reimbursement of $15.00.

11-11-03	97022-22	$16.89	$0.00	G	$16.89	Medicare Fee Guidlines Rule 134.202(C)	At the time an insurance carrier makes payment or denies payment on a medical bill, the insurance carrier shall send, in the form and manner prescribed by the Commission, the explanation of benefits to the appropriate parties. The explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s). A generic statement that simply states a conclusion such as "not sufficiently documented" or other similar phrases with no further description. Therefore, recommend reimbursement of $16.89
12-01-03	99213	$59.00	$0.00	N	$59.00	Medicare Fee Guidlines Rule 134.202(C)	Requestor submitted relevant information that supports documentation criteria and delivery of service for 99213. Recommend reimbursement of $59.00.
12-08-03	99213	$59.00	$0.00	N	$59.00	Medicare Fee Guidlines Rule 134.202(C)	Requestor submitted relevant information that supports documentation criteria and delivery of service for 99213. Recommend reimbursement of $59.00.
12-11-03	97022-22	$16.89	$0.00	No EOB	$16.89	Medicare Fee Guidlines Rule 134.202(C)	Requestor submitted proof of receipt by the carrier of their "Request for Reconsideration." Therefore, the disputed service 97022-22 will be reviewed according to the Medicare Fee Guidelines. Recommend reimbursement of $16.89.
12-22-03	99213	$59.00	$0.00	Y	$59.00	Medicare Fee Guidlines Rule 134.202(C)	The requestor billed the correct MAR according to the Medicare Fee Guidelines. Therefore, recommend reimbursement of $59.00.
TOTAL		$225.78					The requestor is entitled to reimbursement of $225.78.

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) and in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (C); plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable for dates of service 11-04-03 through 12-22-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 15th day of October 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

PR/pr

May 20, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-2117-01
TWCC #:
Injured Employee:
Requestor:
Respondent:
------ Case #:

------ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ------ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ------ for independent review in accordance with this Rule.

------ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ------ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception

to the ADL requirement. This physician is board certified in physical medicine and rehabilitation and is familiar with the condition and treatment options at issue in this appeal. The ------ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ------ for independent review. In addition, the ------ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 33 year-old male who sustained a work related injury on ------. The patient reported that while at work he injured his low back when he was attempting to hold side rails weighing approximately 300 pounds. A MRI of the patient's lumbar spine performed on 10/29/03 showed central and right of center L5-S1, 3mm focal protrusion with mass effect on the right L5 root and its lateral recess. Treatment for this patient's condition has included medications, physical therapy consisting of aquatic therapy, massage therapy, electrical stimulation, ultrasound and therapeutic exercises. The patient has also participated in pain management and work hardening program. The diagnoses for this patient have included lumbar HNP, and lumbosacral neuritis.

Requested Services

Patient reevaluation, elec stim, mas ther, ultrasound, ov, aquatic ther, ther exer, psychiatric diag exam from 11/4/03 through 1/8/04.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Initial exam 10/24/03
2. MRI report 10/29/03
3. Progress notes 11/4/03 – 1/8/04
4. Pain Management notes 10/29/03 – 1/13/04

Documents Submitted by Respondent:

1. No documents submitted

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is partially overturned.

Rationale/Basis for Decision

The ------ physician reviewer noted that this case concerns a 32 year-old male who sustained a work related injury to his back on -----. The ------ physician reviewer indicated that the patient had been treated with physical therapy followed by a work hardening program that began 11/5/03. The ------ physician reviewer explained that the work hardening was initiated before the patient underwent an adequate trial of traditional therapy. The ------ physician reviewer noted

that the patient initially responded to the treatment rendered evidenced by an improvement in range of motion of the lumbar spine. However, the ------ physician reviewer explained that the patient's symptoms remained the same after 12/17/03. The ------ physician reviewer also explained that the patient's condition and declined by the end of 12/03. Therefore, the ------ physician consultant concluded that the patient reevaluation, elec stim, mas ther, ultrasound, ov, aquatic ther, ther exer, psychiatric diag exam from 11/4/03 through 12/17/03 were medically necessary to treat this patient's conditon. The ------ physician consultant also concluded that the patient reevaluation, elec stim, mas ther, ultrasound, ov, aquatic ther, ther exer, psychiatric diag exam from 12/22/03 through 1/8/04 were not medically necessary to treat this patient's condition.

Sincerely,
